



Moving Forward: Addressing the Health of Asian American and Pacific Islander Women

Little is known about the health of Asian American and Pacific Islander (AAPI) women, a rapidly growing population marked by diverse sociodemographic characteristics, health needs, and access to and use of health services.

This commentary provides broad recommendations for research, program development, and policy development based on the first-ever White House Initiative report on AAPIs. These recommendations address the issues of data, access, civil rights, community capacity, and the need to recognize ethnic subgroups among the AAPI population.

Reflecting on the events of the past year, the recommendations provide direction for public health to address the health and well-being of AAPI women. (*Am J Public Health.* 2002;92:516-519)

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THE YEAR 2001 WAS

memorable in many ways. While the tragedy of the events related to September 11 will indelibly mark our memories, the year will also be remembered for its accomplishments. For the Asian American and Pacific Islander (AAPI) health community, 2001 was a step forward in raising recognition of its constituency. The White House Initiative on Asian Americans and Pacific Islanders released the first-ever President's Advisory Commission report on AAPIs.¹ This report was the culmination of town meetings held across the country to give voice to the issues and concerns of AAPIs. In April 2001, following the release of the report, a conference entitled "Voices From the Community: Building Community Readiness to Improve Asian American and Pacific Islander Health" marked the largest-ever gathering of AAPI health and community leaders. The conference was sponsored by the Asian and Pacific Islander American Health Forum in collaboration with numerous other AAPI health organizations.

Key themes and recommendations that resonated in both the report and the conference provide the framework for this

commentary on the health of AAPI women. These recommendations are as follows:

- To improve data collection, analysis, and dissemination
- To ensure access—especially linguistic access—and cultural competence
- To protect civil rights and equal opportunity
- To strengthen and sustain the community's ability to address its health needs (community capacity)
- To recognize and include Native Hawaiians and Pacific Islanders in federal programs and services

There are over 5.6 million AAPI women in the United States, with origins in nearly 50 countries or ethnic groups. Pacific Islanders, who make up roughly 5% of the AAPI population, are primarily indigenous or native born, while approximately 65% of the 5.2 million Asian American women are foreign born.²

Over 100 different languages and dialects are spoken by AAPIs. According to the 1990 census, nearly 66% of AAPIs speak an Asian or Pacific Islander language at home. Approximately 35% are linguistically isolated, living in

households where no one 14 years or older speaks English "very well."¹ In terms of limited English proficiency, Pacific Islanders are the least limited and Southeast Asians the most limited.

AAPIs are extremely heterogeneous in terms of socioeconomic characteristics by ethnic subgroup. Whereas the 1990 median family income for Asian Americans overall was \$41 583, it ranged from \$14 327 for Hmong to \$51 550 for Japanese. The median family income for Pacific Islanders overall was \$33 955, ranging from \$26 865 for Tongans to \$37 269 for Hawaiians.³

Similarly, rates of poverty vary widely among AAPI groups. In 1990, more than 60% of Hmong Americans and 40% of Cambodian Americans were living below the poverty line, compared with 7% of Japanese Americans and 6% of Filipino Americans.¹ Among Pacific Islanders, nearly 26% of Samoans and 23% of Tongans were living below the poverty line, compared with 9.5% of Melanesians.³

Although these statistics are not comprehensive, it is clear that AAPI women are a diverse group by culture, history, and sociodemographic characteristics.

IMPROVING DATA COLLECTION, ANALYSIS, AND DISSEMINATION

Relatively little is known about the health status of AAPI women and their access to and use of health services.^{3,4} Health and epidemiological studies have been beset with difficulties owing to the relatively small size of the AAPI population, its wide geographic dispersion, and its great diversity. A larger problem, however, is simply the lack of data collection and consideration of the AAPI population and its ethnic subgroups. Historically, AAPIs have been labeled or grouped as “other,” with little to no attention paid to the ethnic subgroups.

While aggregate or summary measures may provide an indication of health risks or problems, these measures should be considered carefully. In general, aggregate measures mask the wide diversity among AAPI women. For instance, although the overall age-adjusted death rate for AAPIs (517.5 per 100 000) is lower than that for non-Hispanic Whites (869.4 per 100 000),⁵ the rate for Samoans is 907.7 per 100 000, compared with 275.2 per 100 000 for Asian Indians.⁶ According to SEER (Surveillance, Epidemiology, and End Results) data, the highest age-adjusted incidence rate of cervical cancer occurs among Vietnamese women (43 per 100 000). This rate is 7.4 times the lowest incidence rate, that for Japanese women (5.8 per 100 000), and 5.0 times that for White women.⁷

This variation among ethnic subgroups is also revealed in measures of access to and use of health services. Overall, 21% of AAPI women have never had a Papanicolaou test (to detect cer-

vical cancer), compared with 5% of White women; among AAPI subgroups, rates vary from 8% for Japanese women to 36% for Vietnamese women.⁸ Moreover, AAPI women are more likely than majority women to face such barriers to health care services as lack of health insurance, lack of linguistic and culturally appropriate care, and poorer care owing to sex and race.

Given AAPI women's rapidly growing population and their cultural diversity, it is important to collect and analyze data for them as a whole and by subgroups. In addition, data and information need to be gathered about best practices and lessons learned from health promotion activities and health interventions, particularly at the community level. Community-based programs and interventions need to be documented, evaluated, and disseminated widely. For a more comprehensive commentary on data collection, analysis, and dissemination, see the 2000 Journal article by Srinivasan and Guillermo.⁹

ENSURING ACCESS AND CULTURAL COMPETENCE

The ability to access health services is a key factor in maintaining and promoting health. As with the general population, lack of insurance coverage is a major barrier to care for AAPI women. Although the following data relate to the total AAPI population, these data do provide some indication of the coverage issues related to AAPI women. According to data from 1999, the uninsured rate among all nonelderly AAPIs was higher than that among non-Hispanic Whites (22.0% vs 12.7%). Among low-income populations (with in-

comes less than 200% of the poverty line), the uninsured rate among AAPIs (42.1%) was higher than among non-Hispanic Whites (28.3%) and Blacks (31.9%). Overall, noncitizens were more likely to be without health insurance than citizens (42.2% vs 26.5%).¹⁰

A recent multiple-language survey on the uninsured in Alameda County, California,¹¹ provides evidence at the regional level showing that people of color and immigrants are disadvantaged in terms of accessing care, owing to lack of insurance coverage and lack of financial resources. Uninsured rates ranged from 20% for Koreans and Native Hawaiians/Pacific Islanders to 6% for South Asians and Japanese. The uninsured rate for non-Latino Whites was 8%.

The results also indicate that an individual is at an increased risk of being uninsured if he or she is a new immigrant, a noncitizen, and of limited English proficiency (Table 1).

A major barrier to care for AAPI women is the lack of linguistically and culturally appropriate services. Individuals with limited English proficiency often experience difficulty in obtaining basic information regarding health and access to health care owing to the lack of translated materials and the lack of trained medical interpreters or bilingual providers. While bridging the language gap is important, equally important is the provider's ability to understand how language is used to express concerns and what assumptions are brought to the provider-patient exchange.¹² For instance, the way a South Asian woman expresses her view of a mental disorder may not directly correspond to a provider's medical understanding

of the mental disorder. A Southeast Asian woman may be more likely to express her mental health problem in terms of complaints such as headaches, fatigue, or poor appetite, which may be less stigmatizing than expressing the problem directly.

Cross-cultural studies indicate that the social elaboration of gender varies from culture to culture.¹³ How women view their roles and responsibilities in terms of themselves as individuals, family members, and community members may profoundly affect how they perceive and act upon their health. AAPI women, particularly those who are foreign born or indigenous, may operate in more of a familial context than most women in the United States. In some cases, this may mean that women are less likely to make independent decisions regarding their health or the health of their children, or they may be more likely to neglect their own health to fulfill their familial responsibilities. According to True and Guillermo, AAPI women are socialized from birth to “sacrifice their own personal needs for the good of their husbands and children. Such training (socialization) often leads to their ignoring or denying their own pains or symptoms so that their families' needs are properly taken care of.”³ Clearly, there is a need for both linguistically appropriate services and culturally competent services that account for gender.

PROTECTING CIVIL RIGHTS AND EQUAL OPPORTUNITY

For women of color, the intersection of gender, race, and class has defined and determined who has access to resources, the

TABLE 1—Uninsured Rates (%) for Nonelderly Adult (Aged 19–64) Asian Americans and Pacific Islanders (AAPIs), by Nativity, Citizenship, and English Proficiency: Alameda County, California, 2000

Racial/Ethnic Group	US Born	Immigrant	Citizen	Noncitizen	English Interview	Non-English Interview
AAPI	5	18	11	23	13	27
Chinese	5	16	12	22	14	16
Vietnamese	... ^a	27	19	39	... ^b	24
Korean	... ^a	25	11	34	... ^b	25

Source. Ponce et al.¹¹

^aNo observations.

^bSmall sample size precluded estimates.

amount and availability of resources, and how resources are provided.¹⁴ Discrimination by gender and race in the arenas of employment, housing, and education has had a deleterious impact on the quality of life and well-being of women of color. Issues of racism and sexism have directly influenced the health care of women of color in terms of research and the delivery of health services.

Until recently, women's health advocates have focused on reproductive health, paying less attention to primary care and preventive health.¹⁵ Women were often excluded from clinical trials, leaving many unanswered questions about health and strategies to improve health. Similarly, in the arena of health services research, research involving women often focused on maternal and child health issues or use of reproductive health services. Data and research focused directly on women of color, including AAPI women, have been lacking.^{1,4,16,17}

STRENGTHENING AND SUSTAINING COMMUNITY CAPACITY

Successful health promotion activities and health interventions are more often than not

conducted at the community level. Community-based services, including community health centers and community-based organizations, are critical to maintaining and improving the health of AAPI communities. Centers such as the Chinatown Health Clinic in New York City and Asian Health Services in Oakland, Calif, provide examples of how community-based health centers can reach otherwise disenfranchised populations by tailoring their outreach and services specifically for their target populations.

National organizations such as the Asian Pacific Islander American Health Forum, the Association of Asian Pacific Community Health Organizations, and the National Asian Women's Health Organization play pivotal roles in garnering resources and political support for health-related activities at the national, state or local, and community levels, but more effort is needed.

Additional resources and support are needed to strengthen the ability of community-based organizations and agencies to serve the rapidly growing AAPI population. This support should include public-private partnerships to develop innovative strategies to identify and address the health needs of AAPI women and families. Further efforts are

needed to develop a culturally competent workforce, particularly to provide services for underrepresented women from ethnic groups such as Southeast Asians, Native Hawaiians, Pacific Islanders, and emerging AAPI communities such as Thai Americans, Malaysian Americans, and Melanesians.

IMPROVING HEALTH AMONG PACIFIC ISLANDERS

The grouping of AAPIs as a whole is a political construct. Indeed, Native Hawaiians/Pacific Islanders successfully argued that they should be grouped independently from Asian Americans for the 2000 census. Aggregate measures lumping Asian Americans and Pacific Islanders together mask the poorer health outcomes for Pacific Islanders (e.g., higher infant mortality, lower life spans, high rates of diabetes).¹⁸ Efforts to improve population health among Pacific Islanders should acknowledge the unique circumstances of this population given its geographic isolation from the continental United States and the global environmental and economic forces that shape their environment.

In conclusion, important steps have been taken to voice the

health needs of AAPI women and their families. Yet, as we look forward to 2002 and beyond, there is much progress to be made. As a direct result of September 11, many AAPI women and their families are still struggling to cope with the loss of loved ones; the businesses and households of New York's Chinatown (along with other communities located in Lower Manhattan) are contending with a sharp economic downturn beyond that of the general recession; and South Asians and Muslim Asians are dealing with the rise of racial profiling.

As we look to the future, public health efforts must address the health needs of this population. In addition to the broad recommendations described above, particular efforts in research, program development, and policy development need to address issues of mental health, aging and long-term care, cardiovascular disease, tobacco use, and access to reproductive health services. These are just a few of the many issues that must be addressed. AAPI women play an integral role in their families, their communities, and in our nation. Ensuring their health will benefit us all. ■

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